EARLY INTERVENTION PROGRAM
Nebraska Individualized Family Service Plan (IFSP)

CONFIDENTIAL

Child's Name: _____ Phone: _____ Address: _____

_____

Child's Birthdate: _____ Social Security Number: _____ Medicaid Number: _____

Date of Referral to Early Intervention _____ Date of Consent for Evaluation _____ Date of MDT _____

Family's language choice: _____ Family would like an Interpreter ❑ Yes ❑ No

Parent(s)/Guardian:

Name: _____ Home Phone: _____ Address (if different) _____

Role _____ Work Phone: _____ _____

Name: _____ Home Phone: _____ Address (if different) _____

Role _____ Work Phone: _____ _____

Name: _____ Home Phone: _____ Address (if different) _____

Role _____ Work Phone: _____ _____

Name: _____ Home Phone: _____ Address (if different) _____

Role _____ Work Phone: _____ _____

Name: _____ Home Phone: _____ Address (if different) _____

Role _____ Work Phone: _____ _____

If you have any questions about this plan or any of the people working with your child, please call the person listed as Services Coordinator.

Name: _____ Phone: _____ Agency/ Address: _____

IFSP Meeting Dates:

Interim _____ / _____ Initial _____ / _____ Annual _____ / _____ Transition _____ / _____
(Date sent) (Date sent) (Date sent) (Date sent)

Periodic Review _____ / _____ Periodic Review _____ / _____ Periodic Review _____ / _____ Periodic Review _____ / _____
(Date sent) (Date sent) (Date sent) (Date sent)

Name of Child _____

CONFIDENTIAL

DATE:	FAMILY'S CONCERNS AND DESIRED PRIORITIES:

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Name of Child _____

CONFIDENTIAL

DATE	CHILD AND FAMILY'S STRENGTHS:

(--------- Denotes Periodic Update) Name of Child _____ **CONFIDENTIAL**

CHILD'S PRESENT LEVELS OF DEVELOPMENT

Area/Date of Evaluation | Current Abilities

Vision / __ / ___ / __ ___ yrs ____ mos _____

----- / ----- / ---- / ----- yrs ------- mos ----------

Hearing __ / ___ / __ / ___ yrs ____ mos _____

----- / ----- / ---- / ----- yrs ------- mos ----------

Health / __ / ___ / __ ___ yrs ____ mos _____
Status

----- / ----- / ---- ----- yrs ------- mos ----------

CHILD'S PRESENT LEVELS OF DEVELOPMENT (CONT'D)

Area/Date of Evaluation — Current Abilities

Cognitive/
Thinking Skills

___ /___/ __ / ___ yrs ____ mos _____

----- /-----/ ---- / ----- yrs ------- mos ----------

Communication
Skills

___ /___/ __ / ___ yrs ____ mos _____

----- /-----/ ---- / ----- yrs ------- mos ----------

Social/Behavior
Skills

___ /___/ __ / ___ yrs ____ mos _____

----- /-----/ ---- / ----- yrs ------- mos ----------

CHILD'S PRESENT LEVELS OF DEVELOPMENT (CONT'D)

Area/Date of Evaluation | Current Abilities

Self-Help/Adaptive Skills

___ /___/ __ / ___ yrs ____ mos _____

----- /-----/ ---- / ----- yrs ------- mos ----------

Fine Motor Skills

___ /___/ __ / ___ yrs ____ mos _____

/ ---- /-----/ ---- ----- yrs ------- mos ----------

Gross Motor Skills ___ /___/ __ / ___ yrs ____ mos _____

----- /-----/ ---- / ----- yrs ------- mos ----------

Name of Child _____

CONFIDENTIAL

GOAL/OUTCOME:

Goal/Outcome _____
_____
_____

Child/Family strengths and resources related to this goal:

What will be done/by whom:

Progress will be reviewed _____ by _____ through _____
(How Often) (By Whom) (How Measured)

Plan Review for this Goal
Date: Next Steps:/Comments:
How much progress

Name of Child _____

CONFIDENTIAL

GOAL/OUTCOME:

Plan Review for this Goal

Date:

How much progress

Next Steps:/Comments:

School District # _____ Name of Child _____ **CONFIDENTIAL**

❑ Interim ❑ Initial ❑ Annual ❑ Transition ❑ Periodic Review Date:_____

Are there special conditions for safe transportation for this child?

THE SERVICES THAT WILL BE PROVIDED TO SUPPORT ALL GOALS AND OBJECTIVES ARE:

Service	How often? Where? Group/Individual? Natural Environment?	How much?	When will the service Start/End?	Who pays?	Who's responsible?

Include a justification of the extent, if any, to which a service will not be provided in a natural environment.

_____

_____

_____

_____

School District # _____ Name of Child _____ **CONFIDENTIAL**

❑ Interim ❑ Initial ❑ Annual ❑ Transition ❑ Periodic Review Date:_____

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School District # _____ Name of Child _____ **CONFIDENTIAL**

IFSP TRANSITION PLAN

Transition Conference Date: _____ Estimated Transition Date: _____

What Needs to be Done	Who is Responsible	Time Line	Date Completed

School District # _____ Name of Child _____ **CONFIDENTIAL**

IFSP TRANSITION PLAN

Transition Conference Date: _____ Estimated Transition Date: _____

What Needs to be Done	Who is Responsible	Time Line	Date Completed

Name of Child _____ **CONFIDENTIAL**

CHILD/FAMILY TEAM

Team Members **Present** at the Meeting: ❑ Interim ❑ Initial ❑ Annual ❑ Transition ❑ Periodic Review Date:_____

Print Name:	Signature:	Role:	Address & Phone:

Others Who are Part of the Child/Family Team:

Name:	Role:	Address & Phone:	Family Initial for Copy of Pages Sent

Parent's/Family

I (we) understand the content of the IFSP and give consent for all services in the IFSP to begin unless indicated below. Yes ___ No ___

I(we) understand that a copy of the IFSP will be distributed within 7 calendar days. Yes ____ No ____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Any Comments: